NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand, under the ***HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPA)***, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT***, containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its ***NOTICE OF PRIVACY PRACTICES*** from time to time and I may contact this organization at any time at the address listed below to obtain a current copy of the ***NOTICE OF PRIVACY PRACTICES***.

The Nova Dental Center

7004 Backlick CT

Springfield, VA 22151

703.256.2605

I understand I may request in writing you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you agree then are bound to abide by such restrictions.

Signature: ____ **Date:** ________________________________

Patient Name (Please Print)**:** ____

Relationship to Patient: ____

OFFICE USE ONLY

I attempted to obtain the Patient's Signature in acknowledgement on this ***NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT***, but was unable to do so as documented below:

Date: ________________ Initials: ______ Reason: ____